Bupa Care Homes (ANS) Limited

Meadbank Care Home

Inspection report

Parkgate Road
Battersea
London
SW11 4NN

Tel: 02078016000

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17 April 2019

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service: Meadbank is a care home; people receive accommodation, nursing and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered for 176 people and 105 were receiving care at the time of our inspection on the days of the inspection.

The home is based on four floors, each named after a different London bridge (Albert, Chelsea, Lambeth and Westminster). Each floor has a private wing and the private wing is collectively called "London Bridge". The number of people and staff on each floor varied in response to their needs.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

People's experience of using this service:

Following the last inspection, we asked the provider to show what they would do to improve the key questions Safe, Effective, Caring, Responsive and Well-Led to at least good. At this inspection we found the provider had made good progress against all the breaches of regulations and had improved the outcomes for people because:

The provider had taken appropriate steps to identify and manage risks to people using the service. Where risks had been identified, the care plans contained clear guidance for staff on how to manage these.

The provider had taken steps to ensure any risks to the environment and equipment were being assessed and managed well. This was helping to keep people, visitors and staff safe.

The provider ensured there were sufficient staff on duty to support people safely and to have time to engage and communicate with people.

The provider had installed and implemented a new call bell system, which was working well. Staff were responding quicker to people's calls for assistance.

Staff records showed that the number of staff who had now completed the training they needed to effectively carry out their roles and responsibilities had increased since our last inspection. Where gaps were found in training the manager was able to give us the dates when this training would take place.

People were treated with dignity and respect because personal care and support took place privately and

staff spoke to people in a respectful way and maintained people's confidentiality.

The provider had ensured that people's rooms met people's preferences for décor, music and/or television programmes.

Although we found the top floor which was mainly for people with dementia was not as bright or as aesthetically welcoming as the other floors, the manager has since written to us with a plan of improvements for this unit.

The service was much more responsive to the needs of people, including those who spent a lot of time in bed. The home had increased the number of activity team members and had improved the way it deployed this team. Activities were now scheduled over seven days per week.

People had person centred care plans that detailed the care and support they needed; this ensured that staff had the information they needed to provide consistent support for people.

The manager and staff demonstrated a commitment to provide meaningful, person centred care by engaging with people using the service, relatives and health and social care providers.

We found that the provider had taken a more proactive role in seeking people's views and resolving any concerns or complaints.

The provider had improved the systems used to monitor and improve the quality of the service. Audits were carried out on a regular basis and action plans developed to ensure changes were made when needed.

We also found at this inspection that:
The provider had followed appropriate safe recruitment procedures when employing staff.

Medicines were managed and stored safely. People received their medicines from staff who were trained to do so.

People's bedrooms, bathrooms, the communal areas and the unit kitchens were clean, well maintained and smelt fresh.

Incidents that had occurred were recorded on an electronic system and monitored by the clinical services manager and action take to mitigate further risks occurring.

Staff were adequately supported by their line managers and had the required knowledge, skills and experience to meet people's nursing and personal care needs.

The service supported people nearing the end of life to have a comfortable and dignified death.

People told us they were supported by caring staff. People commented about staff, "The staff are very good, from the nurses to the manager. They're lovely" and "They [staff] are lovely and kind and look after me so well.

There was a warm and welcoming atmosphere throughout the two inspection days. Staff presented as polite, helpful, happy, and motivated and had confidence in the way the service was managed.

More information is in the full report

Rating at last inspection: At our last inspection, the service was rated Inadequate and the home remained in Special Measures. It was first placed in Special Measures in January 2018. Our last report was published on 8 November 2018.

At this inspection the rating has improved to Requires Improvement in Safe and Well Led and Good in Effective, Caring and Responsive. The overall rating is Requires Improvement..

Why we inspected:
All services rated "inadequate" and placed in special measures are re-inspected within six months of our prior inspection. This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received, and check whether they had complied with their improvement plan following the findings at our last inspection.

Follow up:
We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	**Requires Improvement**

Meadbank Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: Four CQC inspectors, two specialist advisors and three experts by experience carried out this inspection. The two specialist advisors were both registered nurses with expertise in nursing older people and those with dementia. The three experts by experience had personal experience of using or caring for someone who uses this type of care service for elder people, some of whom had dementia.

Service and service type: Meadbank is a care home; people have a range of caring and nursing needs including residential and respite care, dementia, palliative and elder care.

The last registered manager left in October 2018. The service now has a manager in post who is registering with the CQC. Once that registration process is completed this will mean that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: We did not give notice of our inspection on the first day but we did tell the provider we would be returning on the second day.

The inspection site visit activity started on 16 April and ended on 17 April 2019.

What we did:
Before the inspection we looked at all the information we had about the service. This information included statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We received quality assurance reports from two local authority commissioners of services who visit

the home monthly. We also met with the homes 'improvement team,' including area directors and the nominated individual from Bupa to discuss the homes' progress against their action plan they had sent us. We used this information to help inform our inspection planning.

During the inspection we looked at 22 people's care files, including 22 medicines administration records and we looked at eight files of staff recently recruited. We spoke with 52 people who lived at Meadbank and 15 relatives. We spoke with the manager and the area director from Bupa, 50 staff members about how the home was being run and what it was like to work there. We also looked at records relating to the management of the home such as quality assurance audits and policies and procedures.

After the inspection: The provider sent us information about the development of the top floor dementia unit and they sent us updates on staff training records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: People were safe and protected from avoidable harm. Legal requirements were met.

However, the provider will need to demonstrate that these improvements are sustainable over time before this key question can be rated as 'good'.

Assessing risk, safety monitoring and management
At our last inspection we found that people's risk assessments did not always adequately reflect how to keep people safe. We asked the provider to complete an action plan. The provider said they would be compliant by 31 January 2019. At this inspection we found the provider had taken steps and this action has been completed.

• The provider took appropriate steps to identify and manage risks to people using the service.
• The care plans we reviewed contained risk assessments that had been reviewed monthly, and the plans had been changed as people's needs changed. For example, risk assessments for people included the risk of falls, moving and handling, tissue viability, the risk of isolation and risks associated with diabetes.
• When risks had been identified, the care plans contained clear guidance for staff on how to manage these. Safe working systems had been clearly documented, including individual hoist and sling details.
• A 'skin care' care and support plan looked at whether people were at risk of developing pressure sores. This considered any previous history of pressure sores, if they were able to reposition independently, if their skin was fragile and if they were continent. The Malnutrition Universal Screening Tool (MUST) scores were recorded and monitored to identify adults, who were malnourished, at risk of malnutrition (under nutrition), or obese.
• Wound care assessments were up to date and detailed with photographs and body maps for staff to monitor progress. However, the wound photographs did not always show evidence of the use of a wound measuring tape and some of the photographs were of poor quality and did not have the person's name written on them. We spoke with the unit manager about this and they said they would address this with nursing staff, to ensure records were clearly kept of wounds.

At our last inspection we found that risk assessment of the home environment did not always adequately reflect how to keep the home safe including the people who lived or worked there. We asked the provider to complete an action plan. The provider said they would be compliant by 8 February 2019. At this inspection we found the provider had taken steps and this action has been completed.

• At our previous inspection the call bell system was not working adequately and people were at risk of isolation because of this.
• We found the provider had installed and implemented a new call bell system. Staff told us that the new system was working well and confirmed they had received training in its use. Staff commented, "The system is working well" and "The new system is much better than the old one. It is really efficient."

• People also commented favourable about the new system, "The call bell is easy to reach. They [staff] come soon enough especially if they know it's something immediate", "If I ring the call bell they come quickly. I feel safe", "I have a button near my bed and at bedtime it is on my bed so I can reach it. They come in for a few minutes whatever time" and "I push the bell around my neck and they [staff] appear quickly."
• We saw that people could choose the type of call bell they had including a neck or wrist pendent. A unit manager told us for some people who were not able to use the call bell system they had a routine in place to check on them regularly, every 15 minutes.
• Staff were issued with a smartphone through which they accessed the call bell system. A unit manager said, "I expect staff to answer that bell as soon as possible. The expectation is that the allocated staff will check if it goes longer than 90 seconds and the staff is busy then anyone can go. It will alert us all." Call boards were placed around the units in different areas, so staff could easily see who was requiring assistance.
• The provider's policy was that calls must always be answered within at least six minutes of the call bell being activated. We checked the data and found only two people in recent weeks had waited more than six minutes for assistance.
• Risks to the home and equipment were being assessed and managed well.
• A fire risk assessment and action plan was completed in November 2018. Fire panels, fire alarms and fire safety equipment were tested regularly. The domestic supervisor explained there were two fire trainers who with the use of a dummy go through the fire procedures to staff on the floor. Training in the use of fire extinguishers was refreshed yearly.
• The maintenance team had a system in place for on-going monitoring of all equipment; this consisted of daily, weekly, monthly and annual checks. Test certificates for the electrical system, portable appliances, gas safety and Legionella were seen. Annual servicing of equipment such as hoists and baths was completed.
• A monthly 'first impressions checklist' was completed looking at the external and internal environment. We reviewed the reports for these and saw there was an improvement in the audit ratings from November 2018 at 68%, to 84% compliance in February 2019.

Staffing and recruitment
At our last inspection we found that there was insufficient staff to meet people's needs. We asked the provider to complete an action plan. The provider said they would be compliant by 8 February 2019. At this inspection we found the provider had taken steps and this action has been completed.
• During this inspection we found there were enough staff on duty to support people safely. We observed staff were available when people wanted them and responded in a timely manner to their questions and requests for assistance.
• Three relatives commented, "There are always plenty of staff and they do a fantastic job at looking after everyone. There seem to be enough whenever I come, even in the evening", "There is always somebody available. My [family member] is bed bound but someone always comes and makes sure she is ok" and "There do seem to be enough [staff] and they come to assist quickly now, it has improved a lot in the last few months, staff are friendlier."
• Staff duty rosters reflected the number of nursing and care staff who were working in the home at the time of our inspection. Rosters also indicated the number of agency nursing and care staff had been significantly reduced in the past six months. For example, during the first quarter of 2019 less than ten percent of staff working in the home who provided direct care had been agency nurses or care workers. This ensured people received continuity of care and support from staff who were familiar with their care needs and preferences.
• Typical feedback from staff included, "The number of care staff on the different floors has definitely increased recently", "The home is so much better now there's more staff on duty" and "I personally feel I have a lot more time to sit and talk with people who live here, which wasn't the case a year ago."
• We observed several instances of staff spending quality time talking with people on a one-on-one basis in their bedroom and the main communal areas. For example, we overheard one member of staff chatting to

someone in their bedroom about their family in a very friendly and relaxed manner.
• The provider followed appropriate recruitment procedures when employing staff. Recruitment files were clearly laid out and included application forms, CV's, interview notes, signed contracts, professional and character references, proof of ID and address and Disclosure and Barring service (DBS) disclosure form. A DBS is a criminal record check that employers undertake to make safer recruitment decisions. Nurse files included details of their NMC registration PINs. Interviews were specific to the role that staff had applied for and interview notes showed that staff were asked about areas of work which demonstrated their suitability for the role.

Systems and processes to safeguard people from the risk of abuse
• Following a serious safeguarding incident in late 2018 that was not actioned immediately, staff at Meadbank Care Home have undergone refresher training in safeguarding people from the risk of abuse. This included what to do to escalate a concern to the local authority or CQC if they think their unit manager or the homes manager has not taken appropriate action in a timely manner.
• Staff told us they felt confident that if they raised any concerns they would be listened to. One care worker said, "I will always raise any concerns. The managers do listen; [unit manager] is so approachable."
• People commented "I'm very happy with them [staff]. Yes, I feel safe; nobody can come here to my room [without my permission]. They're [staff] always around", "I don't fear anything [here]" and relatives commented, "She [relative] feels safe living at the home. I would soon notice it if anything was wrong" and "[Family member] is safe here. If anything was amiss she would let us know and we come regularly so would know if she was not safe."
• A 'Bupa Code' poster providing guidance around risks/incidents and health and safety was on display on the units. It included details about whistleblowing contact details.

Using medicines safely
• All medicines were managed and stored safely. People received their medicines from staff who were trained to do so and who had regular assessments to ensure they remained competent to administer medicines. We observed the registered general nurses (RGN) administer the lunchtime medicines. They were friendly and patient and gave people the time they needed to take their medicines.
• We reviewed a sample of twelve medicines administration records (MARs), these had been completed accurately. There were no unexplained gaps or omissions.
• People's MARs were well organised, complete and up to date. They included important information such as allergies and an up to date photograph of each person.
• Where people were insulin dependent for diabetes, there were body site maps to ensure insulin injections were not always administered in the same place. Recommended good practice is to rotate injection sites rather than injecting into the same place each time. Injecting into the same spot can cause lip hypertrophy, the build-up of fat under the skin, which can slow the absorption of insulin.
• People on anticoagulant medication such as warfarin had specific care plans and risk assessments in place. Covert medicines were managed safely according to NICE guidelines.
• The unit managers completed monthly medicine audits. This helped spot any errors or mistakes.

Preventing and controlling infection
• We spoke with several members of the domestic staff and they commented, "Our job is to make sure everything is clean, the rooms and communal areas. Every day every single room is cleaned. The housekeeper selects certain rooms for a deep clean. A deep clean includes moving the bed and disinfecting the room", "We have all the equipment we need and more" and "The housekeeping team are putting in a lot of effort, they are trying their hardest."
• We saw cleaners cleaning communal areas and bedrooms during the inspection, using appropriate equipment and notices such as 'caution wet floor'.

• People and relatives commented, "It is clean, the staff do not stop tidying and cleaning", "It is always clean and they keep a jolly atmosphere even in tricky times" and "They have had issues with cleanliness and repairs but this seems to be sorted now the new manager is here. It is all more ship shape now."
• People's bedrooms, bathrooms, the communal areas and the unit kitchens were clean, well maintained and smelt fresh. Air scent dispensers and hand sanitiser were available in corridors.
• Cleaning records showed that the medicine fridges and clinical rooms were cleaned regularly.
• Infection control and hand washing guidelines were on display in bathrooms. Quarterly infection control audits were completed which showed an improvement and a high level of compliance. In June 2018 compliance was 79.3%, this had increased to 89% in December 2018 and further still to 95% in March 2019.
• A hand hygiene audit was completed in December 2018 which showed that staff were following appropriate procedures in relation to hand hygiene.

Learning lessons when things go wrong
• Incidents that had occurred were recorded on an electronic system and monitored by the clinical services manager. These evidenced what had occurred, the action taken, whether the necessary notifications were submitted if required.
• One staff member explained the process for incident reporting, telling us, "Incidents get reported to the nurses who upload information onto Datix [data base system] for on-going monitoring by [the clinical lead]."
• A clinical risk meeting was held weekly looking at a number of clinical issues that had occurred such as people on special diets, people with sustained weight loss, falls and covert medicines administration.
• From the analysis of information of incidents the home was working with Wandsworth CCG on a falls management project and was hoping to start a project 'The Significant 7.' This is a project on the prevention of deterioration in care home residents in order to prevent inappropriate hospital admissions.
• The incident reporting, the clinical walk-a-rounds and audits allowed for trends and learning to be identified and these were shared during the nurse meetings, daily meetings and general staff meetings.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience
At our last inspection we found that staff were insufficiently trained to meet people's needs. We asked the provider to complete an action plan. The provider said they would be compliant by 8 February 2019. At this inspection we found the provider had taken steps and this action has been completed.

• Staff had the required knowledge, skills and experience to meet people's nursing and personal care needs. Staff records showed sufficient numbers of staff had now completed the training they needed to effectively carry out their roles and responsibilities.
• People and relatives commented about staff skills and experience, "They [staff] do make me feel safe and they [staff] are confident, there is no dithering about", "Yes I feel they know what they are talking about with me and know all about what help I need which I'm pleased about", "I'm very happy with the level of expertise. They [staff] are very knowledgeable when you ask them things"
• We found staff had now received up to date training in relation to dementia awareness, infection control, moving and handling, fire safety awareness, safeguarding adults, managing behaviours considered challenging, nutrition and food safety and hygiene, and safe use of bedrails. All of which had been identified as a training shortfall at the last inspection.
• The clinical lead nurse told us all nurses had either completed or were booked to attend additional clinical training which included falls prevention and managing pressure sores.
• The manager told us that all new staff were required to complete an induction in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new social care workers.
• Staff demonstrated a good understanding of their working roles and responsibilities and spoke positively about the training they had received. They said it was always relevant to their role and had improved in the last six months.
• One member of staff remarked, "The training is much better now. Always relevant to our job and on-going," while another member of staff told us, "I think the training has got better lately and unlike before if you don't do the training they [the provider] say you must."
• However, all the improvements described above regarding staff training notwithstanding, staff had not received any autism, diabetes or epilepsy awareness training, despite supporting a small number of people with these conditions. We discussed these training shortfalls with the manager who acknowledged staff would benefit from receiving this training. They agreed to ensure sufficient numbers of staff who supported people with the aforementioned needs completed autism, diabetes and epilepsy awareness training.
• Since the inspection the manager has confirmed that diabetes awareness training will take place on 7 May 2019 and epilepsy awareness training on the 25 and 26 April 2019 and additional coaching from a Bupa specialist has been given to nursing staff over two days on diabetes and epilepsy care planning. A care plan

writing and operational essentials training has been booked for the 10th May to further assist staff knowledge. Autism awareness training was planned for the 11 June 2019.

• Staff were adequately supported by their line managers.
• The provider operated a rolling programme of regular supervision (one-to-one meetings) and annual appraisals where staff were encouraged to reflect on their working practices and identify their training needs.
• Records indicated staff at all levels had received at least one individual meeting with their line manager in the first quarter of 2019 and had their overall work performance appraised at the end of 2018.
• Nurses also received regular supervision and annual appraisals. They knew when their revalidations were due and said the clinical services manager or unit managers were always available to support them when revalidating. Revalidation is the process all nurses in the UK need to follow every three years to maintain their registration with the Nursing Midwifery Council (NMC).
• Staff told us they were encouraged to talk about any work-related issues and training needs they might have at these meetings with their line manager. One member of staff said, "I feel we're working better as a team these days and the support I get from my line manager has definitely improved lately." Another member of staff remarked, "We tend to have a supervision meeting with the nurse who is in charge of us three or four times a year, which includes the big end of year assessment [appraisal]."
• A visiting healthcare professional said, "The nurses [RGNs] are confident in their skills and always followed recommendations such as monitoring people's blood pressures or taking bloods when required." The RGNs said that they could discuss any specialised training requirements with the clinical lead or the manager and that they were open and responsive to suggestions.

Supporting people to eat and drink enough to maintain a balanced diet
• People commented about the food, "The food is lovely. There's a great variety and lovely food", "Yes, I like it [food]. They help me to choose what I would like and tell me what it is. If you don't fancy something they will make you something else. I fancied omelette and they made one" and "I like my food, especially Caribbean food. To be fair to the chef he does it well, such as rice and peas."
• Where people had been assessed for additional nutritional needs, they had access to specialists such as dietitians or the speech and language therapists (SALT).
• As a result of a nutrition audit, the provider had identified a need for staff to attend training in hydration and nutrition and this had been actioned and arranged for the end of April 2019.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support
• Since our last inspection a new GP practice, Battersea Fields has taken over the care of people at Meadbank Care Home. Staff told us the GPs visited the home daily and were a young team who were interested in keeping people healthy to help prevent illness. Staff said they are coming up with good advice that they can implement.
• Care plans showed people had access to healthcare professionals, for example physiotherapists were actively involved in supporting with falls management, and the community mental health team (CMHT) were involved in supporting people with behaviours that may challenge.
• People told us "I've seen the dentist recently and the doctor comes to see me." One person also told us they went on a regular hospital outpatient appointment by car and staff always accompanied them. A relative commented "It has got better and I am happier with this, it seems a bit more organised and they feedback information to me more often."

Adapting service, design, decoration to meet people's needs
• Each floor had bedrooms, bathrooms, lounges, dining rooms and small kitchens. The ground floor had

direct access to the gardens. Some but not all of the doors to the garden were unlocked and so easily accessible to residents.
• We saw people in the front garden, siting round a table and chatting. We also saw staff bringing people a drink and sitting chatting with them.
• Three of the floors were bright and airy, with plenty of space for people to walk around or sit where they wanted to. Hallways were bright and neutrally coloured and the lounge had defined areas of seating. There were murals on the walls and areas of interest including resident artwork, photograph collages of activities and the weekly activities were detailed on notice boards including church services at the home.
• The top floor which was mainly for people with dementia was not as bright or as aesthetically welcoming as the other floors. We spoke to the manager about this and they explained the dementia lead from Bupa was due to visit on the 25 April 2019. The manager has sent us their report and recommendations for making this unit more dementia friendly and accessible.
• Suggested changes include addressing the physical issues such as lighting, colour contrast, signage, textures and sensory stimulation as part of the solution. Also developing positive links between service provision and delivery alongside proposed environment changes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law: Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• People's care plans clearly described who had capacity to make decisions for themselves and who did not.
• A unit manager demonstrated a good understanding of the MCA and DoLS. They had applied for DoLS on behalf of people using the service. We saw clear records of restrictions that had been authorised by the supervising body (the local authority) for people's protection and in their best interests, which were kept under constant review.
• Staff had completed MCA and DoLS training, understood who they supported lacked capacity and always asked for people's consent before commencing any personal care tasks. However we also spoke to a few staff who were unable to tell us their understanding of DoLS and what it would mean to the people they cared for. We spoke to the manager about this and they said it would be further discussed at team and one to one meetings with staff.
• Consent forms had been completed with people confirming they had agreed with the support provided. However, where family members were making decisions for a person we did not always find evidence of 'Lasting or Enduring Power of Attorney' (LPA/EPA) documents to confirm this agreement. We spoke to the manager and they said they would ensure the documents were available in people's care plans.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence
At our last inspection we found that people were not always treated with dignity and respect. We asked the provider to complete an action plan. The provider said they would be compliant by 8 February 2019. At this inspection we found the provider had taken steps and this action has been completed.
• Personal care and support took place privately to respect people's dignity and maintain confidentiality. For example, bathrooms and toilets were always closed and staff knocked first before entering anyone's room.
• Relatives commented, "They respect [my relative] and listen to her and that makes her happy. She likes a good chat", "They know [my relative] likes his space and independence and he does what he wants really" and "It's all been very dignified for her [relative] and they have respected her wishes and beliefs . We can visit when we want, day or night and are given all the information we need and now they check it's okay to talk about things to us with her first."
• People commented, "They don't always knock on my door and ask if they can come in but they call out instead. I can lock my door which is fine. They are very respectful mostly" and "I feel they treat me with respect and it's all very dignified more often now. They help me to cover up if I'm getting out of bed and they turn their back."
• There was good staff interaction between people and staff, with jokes and friendly chat which helped to maintained people's dignity.
• People were nicely dressed and staff supported people to look comfortable and dress in a way that people preferred, whilst maintaining care about their health. For example, people who wished to go outside were asked by staff if they wanted a coat.

Ensuring people are well treated and supported; equality and diversity: Supporting people to express their views and be involved in making decisions about their care
• People told us they were supported by caring staff. People commented about staff, "The staff are very good, from the nurses to the manager. They're lovely", "They [staff] are lovely and kind and look after me so well. They are just a bit busy sometimes and you get the ones that don't speak much English at night but they do care" and "They really are reassuring and good at what they do. They have sat with me when I've been worried and helped me to do personal things and not made me feel like a baby."
• Relatives commented "They [staff] have lots of time to give when they see it's needed, if your relative is upset or frustrated. They are very calm. I'm very impressed how the staff have got better at being available, they [staff] used to be hard to find [on the unit]" and "[My relative] can't talk or walk or eat by himself. But staff always encouraged him to hold and drink from a beaker himself. The carers are very good to him. They talk to him, he's quite happy as far as I can tell. It's nice to know you can leave him and he's being looked after properly. The carers are lovely; they really are good, if anything happens they always ring me."
• People's cultural needs were being met. People who used the service had support to follow their faith and

initial assessments identified any religious, spiritual or cultural requirements.
• Staff spoke passionately about care being a fundamental quality of their work and this awareness reached across all roles. For example, an office staff member told us, "You treat the residents as family and you just have to do for them what you would do for your own mum or dad."
• We saw examples of caring attitudes from staff, who supported people in an unhurried manner, and who took the time to speak with them. We saw staff stopping what they were doing in order to support someone who was disorientated and help them to where they wanted to go. Other staff sat and joined in with activities for periods of time or were happy for people to sit next to them while they were writing care notes or involved in another tasks.
• This was reinforced through conversations with staff, who confirmed that, regardless of their role, they were encouraged to get to know people and be involved with them as far as they could.
• One member of staff told us, "If I'm doing my job and I see that someone needs help, I won't just go and find a nurse or whatever. I'll settle the person first, and then, after I've made sure they are comfortable, I'll fetch whoever is needed." Another staff member said they would have "no qualms whatsoever" about having a relative live in the home. They said, "Not at all, everyone here is very supportive and the care is great." Another member of staff told us, "I could always work in a different job for similar money, or nearer home. But I love working here with the people."
• Staff worked to make sure that people were treated equally and that their protected characteristics under the Equality Act were respected and promoted. Staff had received training in equality and diversity and people's support plans reflected their spiritual and cultural needs. For example, some people were supported by the service to maintain their faith while others chose not to.
• We saw staff explaining things, offering choice and talking to people in a respectful way. For example, staff explained to people where they were and offer them the opportunity of staying and participating in an activity, or to be assisted in going elsewhere.
• We observed activities staff inviting people to take part and checking with them that that was their choice.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
At our last inspection we found that staff did not ensure care and treatment of people was appropriate, met people's needs and reflected their preferences. We found that care plans did not always address people's preferences relating to support and decisions they would like their family to help with. We asked the provider to complete an action plan. The provider said they would be compliant by 8 February 2019. At this inspection we found the provider had taken steps and this action has been completed.

• People had person centred care plans that detailed the care and support people needed; this ensured that staff had the information they needed to provide consistent support for people. There was information about people's lives, spiritual needs, hobbies and interests that ensured staff had an understanding of people's life history and what was most important to them. This enabled staff to interact with people in a meaningful way. The plans were reviewed regularly and any changes communicated to staff, which ensured staff remained up to date with people's care needs. Daily records described the support people received and the activities they had undertaken.
• A document called "This is me" contained a summary of the person's needs and preferences for hospital or other external appointments where this information might be helpful. Examples of information included in the document were names of friends, hobbies, likes, types of personal care required and support required when eating or drinking. A nurse told us that this helped the person receive responsive care even if they had to be away from the home for some time.
• There were records of visits by external professionals such as doctors or nurses. Records providing consent for others to access their records were present, as were accurate and up to date records relating to other aspects of people's lives which were related to people's choice and decision making, such as 'do not attempt cardio pulmonary resuscitation' (DNACPR) records and DoLS records.

• People received information in accessible formats and the manager knew about meeting the Accessible Information Standard. For example, there were people of Portuguese, French, Hungarian and Albanian origin. We saw Albanian phrases in the person's care plan, cards in Albanian in the person's room and their relative was involved in their care planning. Staff said most of the people understood English and there were care staff and nurses who were able to communicate with people in Spanish, French and Hungarian.
• One member of staff told us, "As a Portuguese speaker it makes total sense I support Portuguese speaking people here as I obviously speak their language and know their culture." Another member of staff told us, "I learnt German as a child and I often have conversations in German with a German speaking person who lives here, which I know they appreciate,"
• The Accessible Information Standard makes sure that people with a disability or sensory loss are given information in a way they can understand. NHS and publicly-funded adult social care services are legally required to comply with this standard. The standard sets out a specific, consistent approach to identifying,

recording, flagging, sharing and meeting the information and communication support needs of people who use services.

Included in the action plan above was also that the home did not always respond effectively to people's preferences or give them sufficient control over day to day decisions about how they lived, for example with regard to personalising their rooms or control over what they watched on TV or the activities they took part in. At this inspection we found that improvements had been made.

• At this inspection things had improved and the service was much more responsive to the needs of people, including those who spent a lot of time in bed. In addition to the generic activities boards on each floor, there was a copy in each resident's room in both written and pictorial form so that the people and their families could view what was on offer.
• People's rooms were personalised and included personal items and furniture. Clocks and calendars in people's rooms were working and accurate and people were watching a variety of programmes of their choice or listening to the radio.
• There was improved one-to-one interaction between people who were in bed and care and activities staff. Logs were kept more frequently of those visits and recorded in greater detail what kind of interaction had taken place, for example, conversations, or hand massage.
• Where possible, people were encouraged to leave their rooms and make use of the communal areas of the home, and staff were available to support people to take part in any activities on offer.
• The home had improved the way it deployed their activities team. Activities were now scheduled over seven days per week, not five. The activities team were working more independently and sharing information with nursing and care staff directly in team meetings and at handover sessions.
• The activities staff spoke passionately about trying to provide the correct mix of active and social events for people. The activities team manager described how they met as a team, developed ideas based on feedback from people and how each activities staff member used their own personal interests and skills to develop into activities for the home. Examples included karaoke, board games, and television favourites from the past, football, and bridge. There were also opportunities for outings to places of interest or shopping trips.
• One activities staff member told us, "Our job is to make it possible for people to enjoy their day, and we organise things so that all staff can join in and support people, as we don't want activities to be seen as something separate to other care."
• One person told us, "They do put on some nice things here, and you can join in as and when you please. I don't sing, but I enjoy the singing sessions, where people sing along and dance to the music."
• At the time of inspection we saw that activities which had been scheduled took place as planned, and that they took place in areas that were accessible to people, either to participate directly or to observe. There was also a regular Church Communion service for those who wished to take part, as well as visits by external entertainers and local schoolchildren.

Improving care quality in response to complaints or concerns
At our last inspection we found that the complaints procedure and invitation for people to provide feedback was clearly displayed, although the dependency levels of people and their cognitive skills would make it difficult for everyone to be able to complain in this way and we did not see an easy to understand or read version of the complaints process.

• At this inspection we found that the provider had taken a more proactive role in seeking people's views and resolving any concerns or complaints. In addition to clear notices in plain English being placed in all public areas there was more frequent one-to-one interaction with care staff and activities staff to listen to people.
• There was also a greater awareness amongst staff that listening to people's concerns provided an

opportunity to respond to needs rather than see a complaint or concern solely as a criticism.
• Staff we spoke with were positive in their attitude about hearing concerns or complaints from people. One care worker told us, "This is their home. If there's something they don't like, either in what we do or the way we do it, why should they not feel free to say so?" A nurse told us, "They are our family, in a way, and we wouldn't want our own families to be afraid of telling us things they don't like. Otherwise, how can we put it right?"
• People told us they felt they knew who to speak with if they had a concern. One person told us, "I can tell anyone if I'm not happy. Either I tell the nurse or I tell the manager when he comes around, which he does often." Another person said, "Apart from odd niggles like the occasional cup of tea being a bit cold there's nothing to complain about. But you just mention it to someone and they do something about it."
• We looked at the complaints log which was stored both electronically and in paper files. Concerns or complaints by people were logged, responded to within timescales and the individual responded to in writing and through individual contact. Procedures for making concerns known made it clear that people could speak to anyone and their concern would be acted on by the manager. Logs of complaints and concerns could be monitored at senior manager level and considered in the context of regional or national findings.
• Sometimes an individual's concern resulted in responsive action that benefitted the home as whole. For example, a concern by someone around missing clothing led to a review by the home and people were informed of the action the home had taken in the style of a notice called "You said, we did," In the case of the clothing issue, the manager and staff had developed a discreet labelling system of small buttons which the laundry staff could use to identify the owner of an item of clothing. Buttons were colour coded for each floor and had the initials of the individual
• There were also examples where people had provided feedback that was complimentary to the staff and manager. One piece of feedback we looked at from a visiting priest said, "I just wanted to send you a short note to say what enormous improvements I have seen over the past year." Another person had written, "I have been here eight days. I have received excellent care and attention from everyone."

End of life care and support
• The service supported people nearing the end of life to have a comfortable and dignified death by working closely with health care services and through consulting people about end of life wishes.
• Although no one was receiving end of life care at the time of the inspection, some people had been willing to discuss their wishes for how and where they would like to be cared for at the end of their lives. Where this was made known it was included in people's care plans.
• Staff had been trained in end of life care. The home had links with a local hospice which provided training and support to staff and the staff spoke positively about their links with the hospice.
• Staff were able to demonstrate their knowledge on how they would treat and monitor the care of people at the end of their life. In addition to practical arrangements such as preparing the person's room and having the correct equipment to provide care, staff also spoke of the importance of maintaining a person's dignity and comfort during this period. One member of staff told us, "It would be detailed in the care plan what our actions should be, and beyond that we would simply be making sure that the person was comfortable, pain free and had company. No one should be left alone."

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

RI: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

However, the provider will need to demonstrate that these improvements are sustainable over time before this key question can be rated as 'good'.

Continuous learning and improving care
At our last inspection we found that the provider did not assess, monitor and improve the service effectively. We asked the provider to complete an action plan. The provider said they would be compliant by 8 February 2019. At this inspection we found the provider had taken steps and this action has been completed.

• The manager, unit managers and staff recognised the importance of regularly monitoring the quality of the service.
• Clinical audit systems were given a high profile and were in place for monitoring service provision. There were systems in place for reviewing, for example, care plans, infection control, falls, risk assessments, safe swallowing plans and physical health conditions.
• Other clinical audits included weekly weights, nutrition, nurses' daily checks, antibiotics, diabetes, epilepsy, and chest infections, medication management and call bell response. There was also a weekly meal audit for one dining room per week on a rotational basis
• There was a clear and easily monitored process to ensure that actions were completed in a timely manner, for example if there had been falls, information was shared efficiently with staff via clearly identified routes of communication. The clinical services manager ensured a comprehensive new post-fall follow up checklist was to be attached to Datix incident forms and submitted to the manager every time a fall occurred.
• The home had made improvements to their call bell system which enabled them to provide speedier and more discreet responses to people. The call bell was a soft telephone-like tone which meant that people were not irritated throughout the day by a harsh hospital-like alarm beep.
• People's emergency evacuation plans (PEEPS) had been updated and were more informative of people's needs should an evacuation of the home be needed.
• The activities team had been increased from three to five staff and activities were offered seven days a week. People who were bedfast received more one to one visits from both the staff and the activities team.
• Staffing levels had increased which gave staff more time to engage with people on a personal level and people's dignity was being respected by staff.
• It was clear that the clinical lead and manager were proactive in their responsibilities to ensure that risks were monitored, evaluated and actioned, thus leading to the delivery of demonstrable quality improvements for the service.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• The manager and staff demonstrated a commitment to provide meaningful, person centred care by engaging with people using the service, relatives and health and social care providers.
• Resident and family and friends meetings were organised, so the manager could explain first hand actions that were being taken to improve the service at Meadbank.
• There was a 'Meal Planning' group of residents who helped to liaise between the chef and residents.
• Staff told us management support was always available for them when they needed it.
• The home had policies and procedures in place and these were readily available for staff to refer to when necessary.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• There was a warm and welcoming atmosphere throughout the two inspection days. Staff presented as polite, helpful, happy, and motivated and had confidence in the way the service was managed.
• The manager was knowledgeable about their responsibilities with regard to the Health and Social Care Act 2014 and demonstrated good knowledge of people's needs and the needs of the staffing team.
• They were aware of the legal requirement to display their current CQC rating which we saw was displayed at the home and on their web site.
• There was an organisational structure in place and staff understood their individual responsibilities and contributions to the service delivery.
• To encourage and develop the staff to provide responsive and effective care the home had created the role of ambassadors. There were several ambassadors, taken from staff in all areas of the home, domestic, caring, nursing and administration. They worked with the staff to hear concerns and ideas and then fed this back to the management for actioning.
• There was also an 'Employee of the Month' award, started in March 2019. The first staff to receive the awards were four healthcare assistants, one RGN and a staff member from housekeeping. This was awarded as a sign that they demonstrated the values and ethos of the home.
• Staff had also held a breakfast club. Staff brought in their favourite breakfast to share and tables were laid out in the reception area. Staff going on and coming off duty had the opportunity to join in. Plans for a 'tea party' and a summer BBQ were being organised.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Systems were in place to monitor and improve the quality of the service. People and relatives were asked for their views on the service and we could see that people were able to express their views and were comfortable to speak with staff about the support they received.
• People and relatives commented about the staff and manager, "I know all the staff and management by name. The manager [named] comes and says hello most days and has time to chat", "Definitely. He [manager] is always knocking and checking in", "Yes, I do and he [manager] is a really nice person, very caring and tactile", "I know him [manager] very well and all the management. He stops me when he sees me to ask if I'm okay with things and how Mum is" and "I feel I can talk to anyone of the management and nurses and they will get things sorted. It is often slow though. This has changed recently and they are on the ball more".
• Other comments included, "I feel I would be listened to and taken seriously by the manager [named]. Feedback I'm sure is welcome, they listen to me more now", "We are reassured that the manager is kind and approachable and would go to him if we needed as feel our opinions and requests would be listened to" and "The management seems much better at getting their staff moving now. I feel more listened to."

Working in partnership with others

• Staff and management worked in partnership with people's families, their social workers, healthcare professionals including the occupational and physiotherapists, tissue viability nurses and the hospice palliative care teams to ensure people received the care and support they need.